SUPPLIES & FORMS

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Supplies & Forms

Supplies

- Please check supplies regularly to avoid delays when supplies are urgently needed. Make appropriate supplies available to all employees;
- Order program supplies for your entity by submitting an Insurance Supply Order form to the EIP Operations Unit addressed to Supply Department at the Employee Insurance Program; 1201 Main Street, Suite 300, Columbia, SC 29201
- Complete the supply order form in detail, indicating the number of packages of the predetermined quantity; if a smaller quantity is needed, specify the exact number needed;
- You may fax your orders to EIP at 803-737-0825. Please DO NOT mail the original of an order form you have faxed. This results in processing delays and duplicate orders;
- You may access the EIP Web site at www.eip.state.sc.us to place orders online. Orders will be submitted the following day for processing in the order received.
- Supply orders are filled as quickly as possible on a first-come, first-served basis;
- Supplies are shipped first class mail (for small orders less than one pound) and UPS for entities not part of the Inter-Agency Mailing Service. During the peak season, supplies may be shipped via UPS to agencies that normally receive Inter-Agency mail. Please include THE GROUP ID NUMBER ON ALL ORDERS. Please allow seven to 10 business days (except during peak periods, October through December, when processing will take longer) before inquiring about your order;
- Packaging methods vary depending on the size of the order;
- The packing list that accompanies each order will have a column for backorders on any stock items being replenished. Do not reorder these supplies. These items will be mailed later when received by EIP;
- Enclosed with all supply shipments is a customer response card and a replacement order form. Complete and return the response card so we will know how we are doing.
- Check your supply of insurance forms to make sure you are using the most current form available. The most current revision date or form number is listed on the supply order form. If you're not sure your form is the most recent, please call the EIP supply office at 803-734-0607 or toll-free at 1-888-260-9430;
- Please direct any questions about insurance forms to EIP Supply Unit at 803-734-0607 or toll-free at 1-888-260-9430; and,
- Check your supply orders and any shipments of supplies as soon as they arrive to make sure you have enough, especially at enrollment time. This way any errors in shipping may be corrected promptly.

Only home offices may order supplies, as they will be shipped directly to the home office for distribution to satellite offices.

Please do not call-in supply orders. If you are in urgent need of supplies, please fax an order to 803-737-0825, then call EIP Supply to inform them that you have faxed an urgent supply request. You may reach EIP Supply at 803-734-0607 or toll-free at 1-888-260-9430.

FORMS
(*) indicates available on the EIP website @ www.eip.state.sc.us

Forms available in BA Manual (may be duplicated)

Forms to be Ordered From EIP Supply (see Page 171)

Active NOE form*
Active NOE form (instructions)*
Active NOE – Permanent Part-Time Teacher*
Active Termination form*
Active Termination form (instructions)*
Basic Life ($3,000) Conversion Post Card
Basic Long Term Certificate of Coverage
COBRA NOE form*
COBRA NOE form (instructions)*
Dental Claim form*
Dependent & Optional Life Request for Conversion
Employment Record for Retirees*
Health Claim form (State Health Plan)
Life – Personal Health Statement (The Hartford late entrant form)*
Long Term Care Employee Enrollment form
Long Term Care Medical Questionnaire
MoneyPlu$ Benefits, Rules & Regulations*
MoneyPlu$ Change of Election form*
MoneyPlu$ Enrollment form*
MoneyPlu$ Medical Spending & Dependent Care Reimbursement Claim form*
Permanent Part-Time Teacher NOE form*
Permanent Part-Time Teacher NOE form (instructions)*
Prescription Drug Reimbursement form*
Prescription Drug Reimbursement form (instructions)*
Retiree Employment Record
Retiree NOE form*
Retiree NOE form (instructions)*
Standard – Accidental Dismemberment Attending Physician Statement*
Standard – Accidental Dismemberment Authorization to Obtain Information*
Standard – Accidental Dismemberment Employee's Statement*
Standard – Basic Life Proof of Death Claim form*

Standard – Instructions for Accidental Dismemberment*
Standard – Instructions for Long Term Disability*
Standard – Long Term Disability Attending Physician Statement*
Standard – Long Term Disability Authorization to Obtain Information*
Standard – Long Term Disability Employer's Statement*
Standard – Long Term Disability Employee's Statement*
Standard – Medical History Statement*
Standard – Medical History Statement (instructions)*
Standard – Supplemental Long Term Disability Enrollment form*
Supplemental LTD – Medical history Statement (Standard late entrant form)
Survivor NOE form*
Survivor NOE form (instructions)*
The Hartford – Accidental Dismemberment/Loss of Sight form*
The Hartford – Group Term Life Portability Enrollment form*
The Hartford – Living Benefits Claim form*
The Hartford – Proof of Death Claim form*
The Hartford – Proof of Death Claim form (instructions)*

Forms on the EIP Web Page (www.eip.state.sc.us)

Active and Retired Dental form
Active and Retired Dental form (instructions)
Active Group Benefits Refusal (for eligible retirees only)
Active NOE form
Active NOE form (instructions)
Active NOE – Permanent Part-Time Teacher
Active Termination form
Active Termination form (instructions)
Change of Address form
COBRA NOE form
COBRA NOE form (instructions)
Dental Claim form
Dependent Social Security Number form
Dependents With Same or Different Last Name form
Employment Record for Retirees
Establishment of Custody form
Incapacitated Child Certificate form
Instructions for Active and Retired Dental form
Instructions for Prescription Drug Claim form
Life – Personal Health Statement (The Hartford late entrant form)
Long Term Care Change Request
Long Term Care Employer Return of Contributions form
MoneyPlu$ Benefits, Rules & Regulations
MoneyPlu$ Change of Election form
MoneyPlu$ Change of Election form (instructions)
MoneyPlu$ Enrollment form
MoneyPlu$ Medical Spending & Dependent Care Reimbursement Claim form
MoneyPlu$ Refusal to Participate Statement
New Hire Certification form
Permanent Part-Time Teacher NOE form
Permanent Part-Time Teacher NOE form (instructions)
Prescription Drug Reimbursement form
Prescription Drug Reimbursement form (instructions)
Refund Request form
Request for Approval form

Request for Blue Cross and Blue Shield Card
Retiree NOE form
Retiree NOE form (instructions)
Standard – Accidental Dismemberment Attending Physician Statement
Standard – Accidental Dismemberment Authorization to Obtain Information
Standard – Accidental Dismemberment Employee's Statement
Standard – Basic Life Proof of Death Claim form
Standard – Instructions for Accidental Dismemberment
Standard – Instructions for Long Term Disability
Standard – Long Term Disability Attending Physician Statement
Standard – Long Term Disability Authorization to Obtain Information
Standard – Long Term Disability Employer's Statement
Standard – Long Term Disability Employee's Statement
Standard – Medical History Statement
Standard – Medical History Statement (instructions)
Standard – Supplemental Long Term Disability Enrollment form
State Optional Life and SLTD Premium Waiver form
Student Certification form
Survivor NOE form
Survivor NOE form (instructions)
The Hartford – Accidental Dismemberment/Loss of Sight form
The Hartford – Group Life Consent for Payment of Living Benefits form
The Hartford – Group Life Living Benefit Option Disclosure form
The Hartford – Group Life Statement of Claim for Living Benefits
The Hartford – Group Life Personal Health Statement Disclosure Agreement
The Hartford – Group Life Personal Health Statement form
The Hartford – Group Life Personal Health Statement form (Employer's Copy)
The Hartford – Group Life Personal Health Statement form (instructions)
The Hartford – Group Term Life Portability Enrollment form
The Hartford – Living Benefits Claim form
The Hartford – Proof of Death Claim form
The Hartford – Proof of Death Claim form (instructions)
Universal Name/Address Change form
Worksite Screening Request form

EIP Online Forms Ordering System

The EIP Web site is a great way to order forms. No longer do you have to contact EIP Supply and place an order, or use your fax machine. Just log on to the EIP Web site and you're just a few clicks away from placing a direct order. Here's how:

1. Click onto the EIP Web site: www.eip.state.sc.us;
2. On the EIP Home Page, you'll see a key icon in the lower left corner. Click on the key;
3. This will take you to the secured log-on screen. There you will enter your:
   - **User-ID** (the letters "BA," plus your group number);
   - **Department number**: (4);
   - **Password**: (The letters "PW" plus the first four (or three if you only have three) letters of your group number). Submit;
4. Under **Categories**, click "On-Line Forms Order";
5. Under **On-Line Forms Order**, click "Forms Order";
6. On the Forms Order Group Verification page, enter your group number again. For the Verification Code, enter the two-digit month and day you are placing the order (i.e. 0731). Submit;
7. Scroll down and now you're ready to place your order on-line by entering the number of packages of forms you want to be shipped to you.

After you've placed your order you will "submit" the order and your computer screen will give you a summary of your order so you can check to make sure it's correct and all inclusive. Please print this screen to secure a copy of your order for your records. Only one order per entity may be placed per day. All orders will be shipped to your home office address, so please do not give your ID numbers to others because you'll be receiving all the orders. Since this Web site is for home office use only, the computer assumes all orders are placed by the home office and will log the orders in this manner. Remember, only one order per entity, per day.

The orders placed will be received by EIP the next business day. Please allow 7-10 business days for your receipt of all orders placed.

If you have any questions about ordering forms over the EIP Web site, please call EIP Supply at 803-734-0607 or toll-free at 1-888-260-9430.

Request for Approval Form

Subscriber:	**SSN:**
Covered group name:	Group number:

Clerical error or delay-clerical errors made on the records of the Plan Administrator, Third Party Claims Processor or Utilization Review Agency and delays in making entries on such records shall not invalidate coverage that would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made not to exceed 12 months contribution by the employee. Terminations are processed no more than 90 days retroactively. Employers are responsible for any premium liability more than 90 days retroactive to the date of termination.

In order for your request to be considered, it must meet the above *Plan of Benefits* statement.

Change requested (example: change from full family to single effective 7/1/99):	
Reason for change: 1. MoneyPlu$	2. Non-MoneyPlu$, therefore:
A. Change of employment status. Date hired:	Date left:
Marriage date: B. Birth/adoption date: Death date: Divorce date:	Child married date: Child turning 25 date: Child employed date: Legal conservatorship date:
Supervisor/insurance representative failed to respond to an employee request made within 31 days	
Explain BA error in detail:	

I certify that this error was a clerical error on the part of our agency, school district or local subdivision and was in no way the fault of the employee for failure to notify us within the required 31 days.

Benefits Administrator's Signature **Date**

Approval: Yes No	Effective date:
Reason for denial:	

Insurance Counselor's Signature **Date**

No retroactive approval will be made unless the definition of error meets the contract specifications.

Student Certification Form

All subscribers electing coverage for dependent children who are age 19 through 24 must complete this form. *The Plan of Benefits* requires that these dependents be full-time students or be approved as incapacitated dependents.

Subscriber's name:	**Subscriber's SSN:**
Employer name:	**Group number:**
Student's name:	**Student's SSN:**
	Student's date of birth:

State group insurance coverage eligibility for dependent children ends at age 19 unless the dependent is enrolled in and attending a high school, trade school, vocational school, technical school or college (not correspondence courses) on a full-time basis as defined by the institution or is approved as an incapacitated dependent. The student can sit out one grading period and still remain eligible for dependent coverage. Summer school is not considered a grading period. If your dependent is not a full-time student, or is incapacitated, contact your benefits office. If your dependent is a full-time student, complete and sign the following statement certifying student status and return it to your benefits office within 31 days of enrollment. Student eligibility ends at age 25.

I certify by this signed statement that the above-named dependent is a full-time student at (school) _____ or will be on (date) _____. He is unmarried and principally dependent upon me for maintenance and support. I understand that it is my responsibility to notify my benefits office within 31 days of a change in my dependent's status as a full-time student or if he no longer is a dependent (he marries or gains employment with benefits). If full-time student or dependent status is lost, the dependent is ineligible for dependent coverage but is eligible for continuation of coverage under COBRA. COBRA coverage must be applied for within 60 days of ineligibility.

I also understand that student or dependent status may be reviewed at the time claims are submitted or at the request of the Employee Insurance Program (EIP) for audit purposes. If selected for review, certification of student status must be provided by the institution my dependent is attending. If at the time of the audit my dependent is not a full-time student or no longer is a dependent, or if I fail to respond to the audit, my dependent's coverage will be terminated. EIP may demand repayment of any benefits paid on behalf of an ineligible dependent.

Employee's Signature **Date**

If you need assistance, contact your benefits office or the Employee Insurance Program at 803-734-0678 or toll-free at 1-888-260-9430.

Dependents with Same or Different Last Name Form

Certification for Children with Same or Different Last Name

Employee's full name:	**SSN:**
Employer's name:	**Group number:**

This form certifies that the individual(s) listed below are the child(ren) of the employee, but they have different/same last names. These are unmarried children and principally dependent upon the employee for maintenance and support. The term child, as used in this Plan, shall mean (1) an employee's natural or adopted child, stepchild, foster child or child for whom the employee has legal custody, and who resides in the employee's home in a parent-child relationship, or (2) for whom the employee provides support and maintenance because of a court order. Documentation of full-time student status is required for all dependents age 19 through 24.

LAST NAMES	INITIALS	DATE OF BIRTH	RELATIONSHIP

STATE OF SOUTH CAROLINA

Sworn before me this ____ Day of _____, 200_____.

Signature:_____

Expiration date:

Employee's Signature **Date**

Establishment of Custody Form

Establishing custody for children: the following information is required, in addition to the Notice of Election (NOE) form, to establish transfer of custody for benefits under the state insurance program.

PERSON(S) ASSUMING CUSTODY	
Name:	**SSN:**
Address:	
Relationship to child:	**Date residence began:**
Who is principally responsible for the maintenance and support of the child? Who is principally responsible for the care, rearing and discipline of the child?	
CHILD	
Name:	**SSN:**
Date of birth:	**Age:**
Address:	
Does child presently have health insurance? **Yes** **No** If yes, give name and address of insurance company, if no, indicate date insurance ended:	
PARENT(S) OF CHILD	
Father's name and address:	
Father's employer:	
Mother's name and address:	
Mother's employer:	
Do the parent(s) of the child to be insured presently have health and/or dental insurance? Yes No **If yes, give name and address of insurance company:**	
REASON FOR CUSTODY TRANSFER	
LIST ANY TERMS OF CUSTODY	
Is custody limited to a specific time? **Yes, specify time period:** **No, permanent placement:**	
DOCUMENTATION SUPPORTING CUSTODY	
Attach court order. **If there is no court order, explain why and attach any other documentation supporting legal custody (for example: letter from parents relinquishing rights, etc.).**	

Dependent Social Security Number Form

Employee's name:	**Employee's SSN:**
Group name:	**Group number:**

Name	**Social Security Number**
1.	
2.	
3.	
4.	
5.	
6.	

Please return the completed form to your benefits administrator.

Incapacitated Child Certification Form

This information is required to substantiate incapacity for an eligible dependent child (must be established prior to age 19 or while a covered full-time dependent student).

SECTION A (To be completed by the subscriber)

Subscriber's Name:	**Subscriber's Social Security Number:**
Active Employee (list Group Name & Number):	Retiree **Cobra** **Survivor**
Dependent's Name:	**Dependent's Date of Birth:** **Dependent's Social Security Number:**
Is this dependent covered by any other health benefits, including Medicare/Medicaid? __ No __ Yes **If yes, name other insurance carrier:**_____ **Effective date of other coverage:**_____ **Identification Number:**_____	
Is the dependent employed? ___ No ___ Yes (if yes, where?)_____	
Is the dependent institutionalized? ___ No ___ Yes (if yes, where?)_____	

I hereby certify that all information provided is correct to the best of my knowledge and that this dependent is incapable of self-support, has never been married and remains totally dependent upon me for support and maintenance.

_____ _____
(Subscriber's Signature) **(Date)**

SECTION B (To be completed by the dependent's physician)

Date incapacity began:	**Date this individual was last examined by you:**
Please provide a statement of the listed dependent's diagnosis. If the diagnosis is mental retardation, please provide a mental age or IQ:	
Would you consider this individual to be permanently and totally disabled and unable to sustain full-time employment? _____ No ____Yes	
Would you consider this individual to be temporarily incapacitated? _____ No ____ Yes **If this is a temporary disability, when do you expect that this disability will allow the individual to seek employment or return to school? (Please give the anticipated date of recovery):**	
Comments:_____ _____ _____.	

_____ _____ _____
(Physician's Signature) **(Date)** **(EIN/SSN)**

_____ _____
(Print Physician's Name) **(Physician's Phone Number)**

(7/2001)

State Optional Life and SLTD Premium Waiver Form

Employee name:	**Employee SSN:**
Group name:	Group number:

Optional Life
Policy No. GL33913

INITIATE OPTIONAL LIFE PREMIUM WAIVER

The employee listed is in a leave of absence due to a total disability and we are requesting that his Optional Life insurance be continued with his premiums waived for up to 12 months from the last day physically at work. His last day physically at work was (date) _____.

TERMINATE OPTIONAL LIFE PREMIUM WAIVER

The employee listed returned to work on (date) _____ and is no longer eligible for the Optional Life premium waiver effective (date) _____.

The employee listed is still in an approved leave of absence status; however, the 12-month waiver of premium has expired and his Optional Life should be terminated effective (date) _____. The employee is being advised of conversion/portability rights, whichever is applicable.

Supplemental Long Term Disability
Policy No. 621144

TERMINATE SLTD PREMIUM WAIVER

The employee listed returned to work on (date) _____ and is no longer eligible for the SLTD waiver effective (date) _____.

Benefits Administrator's Signature **Date**

Send completed form to the Employee Insurance Program.

MoneyPlu$ Refusal to Participate Statement

I have reviewed the written materials and have been given the opportunity to discuss the program with a benefits administrator. I understand the program may offer tax advantages to employees who participate; however, I decline to elect any eligible MoneyPlu$ benefits this year.

Employee's Signature **Date**

Witness' Signature **Date**

I elect to revoke my refusal and participate at the next earliest entry date.

Employee's Signature **Date**

Witness' Signature **Date**

Request for Blue Cross and Blue Shield Card

If you need additional cards for family members, or if card is lost or stolen, complete the form below and return it to Blue Cross and Blue Shield at the address below. Please allow two weeks for requested ID cards.

State Group Customer Service Center
BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
P.O. Box 100605
Columbia, SC 29260-0605

cut here

Please Print Legibly:

Enrollee's Name: _____

Enrollee's Social Security Number: _____

Reason for Request:

_____ Never received an ID card _____ Number needed

_____ Lost/Stolen _____ Number needed

_____ Need additional cards for family members _____ Number needed

Daytime Phone Number: (_____) _____ (be sure to include area code for out-of-state)

Mailing Address: _____

_____

(May need to confirm correct address at Blue Cross Blue Shield prior to requesting ID card)

Enrollee's Signature **Date**

Worksite Screening Request Form

Please complete this screening request form when you have determined the date, time, location and the number of employees in your agency who wish to be screened. Return this form at least six weeks before your proposed screening date to: State Health Plan Prevention Partners, Employee Insurance Program, 1201 Main Street, Suite 830, Columbia, S.C. 29201 or fax to 803-737-0793.

This form will enable our office to schedule your screening in a timely manner. Please check to be sure that all addresses and phone numbers are complete and that building names and room numbers are included. If necessary, please send directions to the screening site. Thank you for your time and effort!

Prevention Partners Coordinator/Benefits Administrator:		
Worksite:		
Worksite street address:		
City:	State:	ZIP code:
Telephone (with extension if necessary):		Fax:
Location of screening (please indicate if at above address). Please include room number(s) and either attach or map out directions below if necessary:		
Proposed screening date:		
Earliest starting time:		
Expected number of participants:		

Prevention Partners Coordinator or Benefits Administrator's Signature **Date**

Aetna
Long Term Care Employer Return of Contributions Form

SECTION A (TO BE COMPLETED BY THE EMPLOYER)	
Employer's name:	
Employee/retiree's name:	**Employee/retiree's SSN:**
Decedent's name:	Decedent's SSN:
Relationship to employee/retiree:	
Effective date of insurance:	Date of death:
Decedent's monthly contribution:	

SECTION B (TO BE COMPLETED BY THE EMPLOYER)	
Beneficiary's name:	Beneficiary's SSN:
Beneficiary's address:	

SECTION C (TO BE COMPLETED BY THE EMPLOYER)	
Employer's authorized signature:	
Telephone number:	Date:

Complete this form and return it with a copy of the death certificate to:

Aetna Long Term Care Insurance Company
ATTN: Lisa Sarno RT52
151 Farmington Avenue
Hartford, CT 06156

(Revised 7/01)

Universal Name/Address Change Form

Retirement systems require a certified true copy of marriage license or court order for name change.

PRINT OR TYPE -- USE **BLACK** INK

_____ _____
Department Name Effective Date

TYPE OF CHANGE:
____ Name ____ Address ____ Both

1. SOCIAL SECURITY # __ __ __--__ __--__ __ __ __

2. NAME _____ _____ _____
First Middle Initial Last

3. STREET _____ APARTMENT # _____

4. CITY _____ STATE_____ ZIP CODE _____

5. HOME PHONE (_ _ _) _ _ _ - _ _ _ WORK PHONE (_ _ _) _ _ _ - _ _ _ _ COUNTY CODE _____
(EIP , if applicable)

6. PREVIOUS NAME (if applicable)

_____ _____ _____
First Middle Initial Last

7. PREVIOUS ADDRESS (if applicable)

_____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

_____ _____
ENROLLEE'S SIGNATURE DATE

_____ _____
BENEFITS ADMINISTRATOR'S SIGNATURE (if applicable) DATE

Distribution:

- Human Resource Office
- Payroll
- Employee Insurance Program
  P.O. Box 11661
  Columbia, SC 29211
- Deferred Compensation
  3700 Forest Drive, Suite 200
  Columbia, SC 29204-9990
- State Retirement Systems
  P.O. Box 11960
  Columbia, SC 29211-1960

LONG TERM CARE CHANGE REQUEST

Please complete Section C, Employee/Retiree Information. Make any requested changes to your file under Section D. Make any requested changes to your spouse's file under Section E. Sign and date the form (Section F). Employees should send the completed form to the benefits office (the Benefits Administrator's signature is required for active employees). Retirees should mail the form directly to the Employee Insurance Program, P.O. Box 11661, Columbia, SC 29211.

Section A

	Policyholder Number	**Policyholder Name**
Policyholder Information	654031	South Carolina Budget & Control Board Employee Insurance Program

Section B

BA USE ONLY Effective date to cancel or decrease coverage: _____

Group Name: _____ Group Number: _____

Section C

___Employee Social Security number: __ __ __ - __ __ - __ __ __ __

___Retiree

(check one) Name: _____ _____ _____

Information Last First Middle Initial

Section D

Employee/Retiree Coverage Change

___ Cancel Long Term Care Coverage

___ Decrease Amount of Long Term Care Coverage

Decrease my current amount of coverage by $_____ dollars (must decrease in increments of $10.00 amounts).
My new daily benefit will be $_____.

Employee/Retiree Beneficiary Change

Beneficiary Information:
Name: _____ _____ _____
(Last) (First) (Middle Initial)
Social Security Number: __ __ __ - __ __ - __ __ __ __
Date of Birth:_____ Relationship to Employee/Retiree:_____

Section E

Spouse's Name: _____ _____ _____
(Last) (First) (M.I.)
Spouse's Social Security Number: __ __ __ - __ __ - __ __ __ __

Spouse Change

___ Cancel Long Term Care Coverage

___ Decrease Amount of Long Term Care Coverage

Decrease my current amount of coverage by $_____ dollars (must decrease in increments of $10.00 amounts).
My new daily benefit will be $_____.

Spouse Beneficiary Change

Beneficiary Information:
Name: _____ _____ _____
(Last) (First) (Middle Initial)
Social Security Number: __ __ __ - __ __ - __ __ __ __

Section F

I certify that the answers and statements on this form are complete and true to the best of my knowledge and belief. I hereby authorize the above changes to be made in accordance with the group policy issued.

Spouse Signature (if applicable) _____ Date:_____

Employee/Retiree Signature _____ Date:_____

BA Signature (if applicable) _____ Date_____

SOUTH CAROLINA
STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM

ACTIVE GROUP BENEFITS REFUSAL

(FOR ELIGIBLE RETIREES ONLY)

AGENCY/SCHOOL DISTRICT_____

AGENCY/SCHOOL DISTRICT GROUP NUMBER _____

ENROLLEE NAME _____

ENROLLEE SOCIAL SECURITY NUMBER _____

MAILING ADDRESS _____

_____

_____

TELEPHONE NUMBER _____

CERTIFICATION:

I HAVE BEEN ADVISED OF MY ELIGIBILITY TO ENROLL IN THE STATE ACTIVE EMPLOYEE INSURANCE BENEFITS PROGRAM. I UNDERSTAND THAT IF I REFUSE TO DROP MY STATE RETIREE INSURANCE BENEFITS, I AM ALSO REFUSING BENFITS THAT ARE OFFERED TO ME ONLY AS AN ACTIVE EMPLOYEE, INCLUDING THE $3000 BASIC LIFE, BASIC AND SUPPLEMENTAL LONG TERM DISABILITY, DEPENDENT LIFE, OPTIONAL LIFE AND MONEYPLU$.

I ALSO UNDERSTAND THAT ENROLLMENT UNDER THE STATE ACTIVE EMPLOYEE INSURANCE BENEFITS PROGRAM WILL NOT ADVERSELY AFFECT MY ELIGIBILITY TO RETURN TO THE STATE RETIREE INSURANCE BENEFITS.

SIGNATURE: _____

DATE: _____

Employee Insurance Program
Accounting Department
PO Box 11661
Columbia, South Carolina 29211

Change of Address Form

Please use the space provided below to make any changes for your group. It is important to list the name of the person at your office that is responsible for remitting the insurance payment or reviewing the billing statement for payment.

GROUP NAME _____

GROUP NUMBER _____

CONTACT PERSON _____

ADDRESS _____

CITY / STATE / ZIP CODE _____

TELEPHONE NUMBER _____

Please mail this form to the address listed above or fax to 803-737-0825. If you have any questions, please contact the Account Representative for your group at 803-734-1696 or toll-free at 1-888-260-9430.

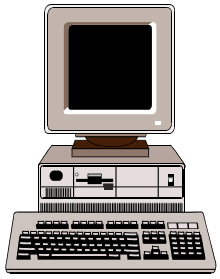
REFUND REQUEST

AGENCY NUMBER_____AGENCY PROCESSOR_____TELEPHONE #_____DATE SENT_____

SUBSCRIBER NAME_____SSN_____MONTHLY BILL COVERAGE CHANGE APPEARS*_____

REASON FOR OVERPAYMENT_____

	HEALTH		**DENTAL**		**OPTIONAL LIFE**	
DATE OF DEDUCTION	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM
	SUBTOTAL:_____		SUBTOTAL:_____		SUBTOTAL:_____	
	DEPENDENT LIFE		**LONG TERM CARE**		**SUPPLEMENTAL LTD**	
DATE OF DEDUCTION	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM	AMOUNT OF DEDUCTION	CORRECT PREMIUM
	SUBTOTAL: _____		SUBTOTAL:_____		SUBTOTAL:_____	



DIVISION OF INTERNAL OPERATIONS
FINANCIAL DATA SYSTEMS
COMPUTER RESOURCES ACCESS REQUEST

PLEASE PRINT OR TYPE ALL INFORMATION

Employer Name:_____

User Name:_____ Date:_____

Current User ID (if Known):_____User Phone #_____

Action Regarding User: Add ☐ Delete ☐ Reinstate Password ☐.

*** APPROVAL AND AUTHORIZATION ***

Requesting Supervisor's Signature:_____

Please note: The initial password assigned below must be changed when this user signs onto the system for the first time and thereafter every thirty (30) days. Password must be at least five (5) characters long.

*** DATA PROCESSING USE ONLY ***

Date Received:_____Date Completed:_____

User ID Assigned:_____Initial Password Assigned: ABCDE

Completed by:_____

Remarks:_____

_____

_____

Completed Copies to:
Requesting Supervisor,
Security Administrator & Financial Data Systems